

Today's date: _____



Patient Information (all information is strictly confidential and will remain with this office)

Name: _____
Last First Prefer to be called

Address: _____
Street City Prov Postal Code

Telephone: _____
Home Work Cell

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Month / day / year

Employed by: _____ Occupation: _____

How did you hear about our office? ___ Facebook ___ Google ___ Yellow Pages ___ Friend/Family

Medical Information

Medical doctor: _____ Telephone: _____

Date of last physical exam: _____ Do you consider yourself to be in good health: _____

Are you presently under the care of a medical doctor: ___ Yes ___ No If yes please specify _____

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:

Do you have any allergies or have you had any reaction to (medications, anesthetics, metals, latex, antibiotics, pain killers, dairy, etc.): _____

Do you have to take antibiotics prior to dental work? If yes, why? _____

Have you had heart surgery? If yes, please specify: _____

Do you have any artificial prosthesis (Joints, heart valve, etc)? If yes please specify: _____

Do you have abnormal bleeding? ___ Yes ___ No Do you become breathless easily? ___ Yes ___ No

Do you have or have had any of the following:

- | | | | |
|--|-------------------------------|---------------------------------|------------------------------------|
| High blood pressure ___ Yes ___ No | Tuberculosis ___ Yes ___ No | Hepatitis type ___ Yes ___ No | Hiv/aids ___ Yes ___ No |
| Amenia ___ Yes ___ No | Headaches ___ Yes ___ No | Chest Pain ___ Yes ___ No | Tested ___ Yes ___ No |
| Sinus problems ___ Yes ___ No | Herpes ___ Yes ___ No | Blood disorders ___ Yes ___ No | Digestive disorders ___ Yes ___ No |
| Low blood pressure ___ Yes ___ No | Glaucoma ___ Yes ___ No | Liver disease ___ Yes ___ No | Thyroid disease ___ Yes ___ No |
| Head Or Neck injuries ___ Yes ___ No | Diabetes ___ Yes ___ No | Asthma ___ Yes ___ No | Arthritis ___ Yes ___ No |
| Venereal Disease ___ Yes ___ No | Cancer ___ Yes ___ No | Rheumatic Fever ___ Yes ___ No | Radiation Therapy ___ Yes ___ No |
| Nervous Problems ___ Yes ___ No | Heart Trouble ___ Yes ___ No | Heart Murmur ___ Yes ___ No | Chemotherapy ___ Yes ___ No |
| Epilepsy ___ Yes ___ No | Kidney Trouble ___ Yes ___ No | Emphysema ___ Yes ___ No | Antidepressants ___ Yes ___ No |
| Alcohol/drug Dependency ___ Yes ___ No | Ulcer ___ Yes ___ No | Psychiatric care ___ Yes ___ No | Stroke ___ Yes ___ No |

Others: _____

Do you smoke? Yes No If so how much? _____ Do you take recreational drugs? Yes No
Women: Are you taking Birth Control Pills? Yes No Are you pregnant? Yes No

This is to certify that I, the undersigned, consent to the performing or the procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures.

Signed: _____

Account Information

Person financially responsible for the account: _____

Dental History

Are you having any discomfort at this time? If yes please specify: _____

Have you been under the regular care of a dentist? Yes No How long since your last dental visit: _____

What was done at that time? _____

Do your gums feel tender or swollen? Yes No

Is there often bleeding when you floss? Yes No

Have you ever been given local anesthetic (freezing)? Yes No

Have you ever had general anesthetic? Yes No

Are you aware of any lump or swelling in your mouth? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Are you anxious to keep your natural teeth? Yes No

Are you tense during your dental visits? Yes No

Are you interested in a method to calm your nerves? Yes No

Describe what you would like done with your teeth: _____

Do you currently experience any of the following?

Loose teeth Yes No Ear ache Yes No Spaced or crooked teeth Yes No

Bad Breath Yes No Gagging Yes No Unexplained nose bleed Yes No

Missing Teeth Yes No Sore Gums Yes No Popping or clicking of the jaw Yes No

Bleeding gums Yes No Headache Yes No Unsatisfactory Dentures Yes No

Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep your appointment we require 48 hours notice, otherwise, it may be necessary to charge for the time lost.

I understand that I am ultimately responsible for the total fees associated with the treatment performed.

Date: _____

Patient/ Guardian signature: _____